Connecticut Department of Social Services
Making a Difference

Testimony before the Human Services Committee

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Commissioner
March 2, 2010

Good morning, Senator Doyle, Representative Walker and Members of the Human Services Committee. I am Michael Starkowski, Commissioner of the Department of Social Services. I am pleased to be here this morning to present testimony on legislation introduced at the request of the department and would like to thank the committee for raising these bills. I am also providing testimony on several other bills with significant impact on the department.

Legislation Introduced at the Request of the Department

S. B. No. 220 (RAISED) AN ACT CONCERNING THE ELIMINATION OF CERTAIN DEPARTMENT OF SOCIAL SERVICES REPORTING REQUIREMENTS.

This bill was raised at the request of the department and again I would like to thank the committee for doing so. This bill would eliminate or amend a number of the statutory reporting requirements that have been placed upon the department. We bring this bill before you not in an effort to circumvent transparency but rather to lighten the large reporting burden on the department so we may focus our efforts on administering our programs.

To give you a few examples, in 17b-14 the department is not asking that the report be eliminated but rather is asking for an extension of time to submit the required report.

Also in 17b-114o the department is required to report to the legislature on the TANF block grant. We are not suggesting that our reporting be eliminated altogether, rather we are asking that we simply be allowed to continue to share the report that we are federally mandated to produce as opposed to having to create an entirely new state report.

Some examples of requirements we wish to eliminate are one time reports as in 17b-342a which was a report on the PCA pilot program and in 17b-366 which was a report on the assisted living pilot.

Other Legislation Impacting the Department

S. B. No. 217 (RAISED) AN ACT LIMITING FINANCIAL INSTITUTION FEES FOR RECORDS NEEDED FOR MEDICAID APPLICATIONS.

This legislation was proposed by the Attorney General's office and would limit the fees that financial institutions may require for records of account needed by the Commissioner of Social Services to determine eligibility for Medicaid.

The department has experienced situations in the past where financial institutions charged fees to Medicaid applicants for documents provided necessary to determine eligibility. These fees are financially burdensome to Medicaid recipients, most of whom are already financially compromised. If an applicant cannot afford to pay the fees and the financial institution refuses to provide the copies, the applicant will be unable to complete the application. Failure to provide the Department with required documents will result in the denial of the application.

We strongly support this legislation.

S. B. No. 281 (RAISED) AN ACT CONCERNING PUBLIC PARTICIPATION IN MEETINGS OF THE PHARMACEUTICAL AND THERAPEUTICS COMMITTEE.

A consumer representative is already a very active member of the P&T Committee. Committee members are appointed by the Governor and represent clinicians, pharmacists, drug manufacturers and consumers. Committee members have established guidelines for public comment. When needed, public comment takes place during the first half hour of the meeting. There appears to be no need for this legislation given the below guidelines already in place as follows:

> A member of the public may submit clinical and other relevant information to the P&T Committee for their review and request an opportunity to speak at the committee meeting.
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> Speakers must submit a written document to the committee at least 2 weeks prior to the meeting at which they wish to speak. The document should outline the subject matter to be covered. The written document may not be more than 10 pages in length (including references and package inserts), and the font not smaller than 12. *Written materials which do not conform to these specifications, will not be distributed or considered by committee members.*
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> The Committee chairperson (or designee) will distribute submitted materials to committee members.
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> At least 1 week prior to the scheduled meeting, the committee chairman will notify those individuals who will be asked to speak at the meeting based on discussion with committee members, interest or questions. These individuals will be given an approximate time for appearance at the meeting. The committee chairman will also notify those individuals whose submitted materials were sufficient and presentation at the meeting will not be required.

The first 30 minutes of each committee meeting will be designated as the public portion of the meeting. Speakers' are limited to a maximum of 5 minutes at the discretion of the Committee Chairman. Questioning by committee members after speakers' presentations may be permitted at the discretion of the chairperson.

Speakers will state their names and identify the company, group, or organization they represent, and only one speaker per company, group or organization is permitted.

S. B. No. 283 (RAISED) AN ACT CONCERNING AUDITS BY THE DEPARTMENT OF SOCIAL SERVICES.

The Department is opposed to Senate Bill No.1085 for the following reasons:

First, this bill is extremely costly. It puts the department in a position of violating federal law, thereby jeopardizing all of the Federal Financial Participation (FFP) funding of the Medicaid program. The state could lose $1.8 billion in FFP. In addition, since this bill affects the audits of all providers, it will cost the Department $15 million in audit recoveries and cost avoidance, annually. Lastly, as this bill will embolden fraudsters and greatly impede the Department's ability to identify vendor fraud, it will cost the Department millions each year in undetected fraudulent claims.

Implementation of this bill will provide a negative incentive to those individuals and corporations that hunger to take inappropriate advantage of the billions of dollars paid out by the Connecticut Medical Assistance Programs. This proposed bill effectively cuts the heart out of the program integrity function of this Department and will actually promote vendor fraud.

Moreover, this bill will place the Department in violation of federal law. In a recent Connecticut Supreme Court decision; Goldstar Medical Services, Inc., et al. v. Department of Social Services, the Supreme Court Justices unanimously found that the Department's auditing method and use of sampling and extrapolation were not only appropriate, they were required by federal law.

In response to a very similar proposed bill in 2005, PA 05-195 was crafted with the assistance of the bill's sponsors and put into law. The Public Act addressed both the providers concerns with the audit process and the Department's federally mandated requirement to audit the billions of dollars paid to providers. Among other things, the Public Act provided for limits on the use of extrapolation and formalized a review process for providers who felt aggrieved by the audit process. The reforms enacted by the Public Act have been successful and the majority of the bill's sponsors have been satisfied with the changes.

Proposed H. B. No. 5056 AN ACT IMPLEMENTING THE MILLIMAN REPORT'S RECOMMENDATIONS TO ACHIEVE COST SAVINGS IN THE HUSKY PROGRAM.

While the biennial budget included rate reductions to the MCOs, the Governor recommends converting HUSKY to a non-risk model with the HUSKY program continuing under an administrative services structure. It is clear that if the legislature moves forward with the ASO proposal, a bill concerning managed care rates would be irrelevant. However, we strongly feel that based on the process and procedures employed at the present time the bill is duplicative and unnecessary.

The department currently solicits sealed bids in order to ensure competition on price. Open bids would undermine that process. Once bids have been unsealed and contractors awarded the right to negotiate, the department then proceeds with the negotiation of the financial terms that are the most advantageous to the state. For this reason the department opposes this provision.

We feel that it is duplicative and unnecessary to conduct an annual audit of the HUSKY program. HUSKY rates are currently reviewed by an independent actuary and certified by the Center for Medicare and Medicaid Services (CMS).

Lastly, we believe that expansion of PCCM state-wide to HUSKY B and Charter Oak would be premature before completion of the evaluation of the pilot program.
For these reasons the department is opposed to this bill.

H. B. No. 5297 (RAISED) AN ACT CONCERNING STATE-WIDE EXPANSION OF THE PRIMARY CARE CASE MANAGEMENT PILOT PROGRAM.

This legislation would require the Department of Social Services to make the primary care case management pilot program available to all HUSKY A clients on a state-wide basis no later than October 1, 2010. The Commissioner of Social Services would be required to report to the joint standing committee of the General Assembly having cognizance of matters relating to human services on the expansion of the pilot program no later than July 1, 2011 and to seek a waiver if necessary from federal law for the purpose of expanding the primary care case management system pursuant to this subsection.

The Department remains committed to developing HUSKY Primary Care, as the primary care case management pilot program is known. HUSKY Primary Care is being introduced gradually in target communities across the state according to the terms contained within the General Assembly's approval of the Department's 1915(b) waiver renewal of March, 2009. The requirement for an independent evaluation to be completed and reported to the committees of cognizance by July, 2010 was also included in the approval of the waiver renewal. The department has begun to have preliminary discussions planning for the evaluation and expects will be completed within the timeframe.

The Department of Social Services believes that it is premature to mandate statewide implementation of HUSKY Primary Care until the program is evaluated, the cost-

effectiveness of the model in Connecticut is determined, and the additional resources necessary for the pilot's success are both measured and identified.

H. B. No. 5328 (RAISED) AN ACT IMPLEMENTING SAGA HOSPITAL RATE INCREASES.

While the SFY 2011 budget did include $66.3 million to cover the cost of increasing SAGA hospital reimbursement rates to the Medicaid rate as part of the SAGA waiver, the budget also assumed $129.5 million in additional federal revenue as a result of the approval of that waiver. Because the SAGA waiver is not expected to be in place before the beginning of SFY 2012, the revenue will not be available in SFY 2011 to offset these costs. Thus, the department opposes the proposed bill because it would increase our expenditures by tens of millions of dollars without the benefit of the additional revenue that would be generated under the SAGA waiver

Section 1 of H. B. No. 5354 (RAISED) AN ACT TO PROVIDE INCENTIVES FOR HOSPITALS TO ADOPT ELECTRONIC HEALTH RECORDS.

> As the single state agency for Medicaid the Department of Social Services is responsible for the administration of the Medicaid EHR incentive program. Accordingly it would not be appropriate for DPH to deem DSS' actions necessary. Furthermore, it is our understanding that the Department of Public Health has raised the issue that this bill could jeopardize the pending application for federal funds under the American Recovery and Reinvestment Act of 2009 and for that reason we oppose this bill.

H. B. No. 5355 (RAISED) AN ACT CONCERNING AN ADVANCED DENTAL

This bill is a scope of practice bill that expands the role of dental hygienists. The activities and licensure practices in the State of Connecticut are under the Department of Public Health and do not fall within the jurisdiction of the Department of Social Services. We feel that the pilot program contemplated in this bill has inappropriately been placed under the Department of Social Services.

Moreover, this type of pilot program is not fundable as a Medicaid service and would not qualify for federal match. This pilot should be funded as a grant under the direction of DPH.

If the pilot were successful, and the scope of practice of dental hygienists were expanded, this could be included as a Medicaid covered service and might be cost-effective. However, this would have to be examined more carefully.

Additional Written Remarks:

H. B. No. 5329 (RAISED) AN ACT CONCERNING REIMBURSEMENT RATES TO PHYSICIANS WHO PROVIDE EMERGENCY ROOM SERVICES TO MEDICAID RECIPIENTS.

This bill would require separate reimbursement rates for emergency room physicians who provide services to Medicaid recipients. This has been an issue for some time about physicians in the emergency room. In the past these professional services were routinely provided by in-house staff. However, increasingly hospitals have contracted with physician groups to provide services in the ER. In some cases there have been audit issues as to whether the physician group is actually independent from the hospital and does not receive a subsidy. DSS medical services policy prohibits payments to physicians who are on salary from a hospital for services provided in the hospital setting. The other issue which has come to light recently is that another DSS policy prohibits payment for ER services if the patient is admitted to an inpatient stay on the same day. This is a good policy, meant to avoid duplicate billing, but it seems to have restricted billing by physician groups who are working under contract to the hospital.

The department agrees that we need to update our physician reimbursement policy to allow contracted physicians to be paid for ER services on the date of admission. We are opposed to language that would require that "any" physician would be paid, since that has the implication that even those physicians who receive a subsidy from the hospital for their services would also be entitled to reimbursement.

While these are typically reviewed on a case-by-case basis we would be willing to work with the committee on language for the bill that would address the new realities of the physician-hospital relationships in the emergency room.

We believe if this language were to move forward, it should be clarified so that physicians cannot receive payment from both the state and the hospital.

The rate paid by the commissioner to [any] a physician who does not otherwise receive a salary or subsidy from the hospital to provide services in the emergency room of said hospital shall be separate and distinct from the rate provided to such hospital for the provision of services.